



Veteran

UIN



Please assess the following conditions:

1. Please select **all** that apply to any anatomical loss or alteration of **testes and scrotum**.

Description	Select
None.	<input type="checkbox"/>
Minor varicocele or hydrocele symptoms.	<input type="checkbox"/>
Moderate (e.g. varicocele with scrotal enlargement, significant scarring, scrotal malposition).	<input type="checkbox"/>
Non-scrotal positioning of testes.	<input type="checkbox"/>
Loss of single testis.	<input type="checkbox"/>
Bilateral loss of testes.	<input type="checkbox"/>

At what age did loss of testes occur (if applicable)? .....

2. Please select **all** that apply to any anatomical loss or alteration of the **penis**.

Description	Select
None.	<input type="checkbox"/>
Circumcision.	<input type="checkbox"/>
Scarring of penis.	<input type="checkbox"/>
Peyronie's disease.	<input type="checkbox"/>
Loss of part of penis.	<input type="checkbox"/>
Loss of all or most of penis.	<input type="checkbox"/>

At what age did loss of penis occur (if applicable)? .....

3. Describe any interference with the function of the penis (consider both sexual and urinary function):

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4. Please select the most accurate description of impairment of **fertility**.

Description	Select One
Normal.	<input type="checkbox"/>
Reduced fertility and / or detectable seminal abnormalities.	<input type="checkbox"/>
Complete infertility.	<input type="checkbox"/>

At what age was the onset of this level of impairment? .....

5. Please list **all conditions** contributing to the reported impairment and indicate the **percentage contribution**. Include any previously known condition(s) and any new condition(s) you have identified. The contribution total must equal 100%.

Condition	Contribution %
e.g. Testicular Cancer	25%
<b>Total</b>	<b>100%</b>

Doctor's signature	Doctor's name	Date	Time to complete form
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